Exhibit 10

Choice HouseCall

17200 E. 10 Mile Rd. Suite 135
Eastpointe, MI 48021
Phone: (586) 279-3200 Fax: (586) 279-3184

Physical Therapy Prescription

Patients Name: _____ Date 6/23/10

Diagnosis: 1. C, T/L Strain

Diagnosis: 2. _____

Diagnosis: 3 _____

Diagnosis: 4 _____

Evaluate & Treat: X Area: CTL Spine

Evaluate & Treat: _____ Area: _____

Evaluate & Treat: _____ Area: _____

Evaluate & Treat: _____ Area: _____

Frequency: 3 times/week Duration: 4 weeks Onset Date: _____

Precautions: _____

Physicians Name: Martin Quiroga, DO

Physicians Signature: _____ Date: 6/23/10

Choice HouseCall
17200 E. 10 Mile Rd. Suite 135
Eastpointe, MI 48021
Phone: (586) 279-3200 Fax: (586) 279-3184

Occupational Therapy Prescription

Patients Name: _____ Date 6/23/10

Diagnosis: 1. Post traumatic H.A

Diagnosis: 2. _____

Diagnosis: 3 _____

Diagnosis: 4 _____

Evaluate & Treat: X Area: Head

Evaluate & Treat: _____ Area: _____

Evaluate & Treat: _____ Area: _____

Evaluate & Treat: _____ Area: _____

Frequency: 3 times/week Duration: 4 weeks Onset Date: _____

Precautions: _____

Physicians Name: Martin Quiroga, DO

Physicians Signature: _____ Date: 6/23/10

Choice HouseCall

22 B109305

17200 E. 10 Mile Rd. Suite 135
Eastpointe, MI 48021
Phone: (586) 279-3200 Fax: (586) 279-3184

Physical Therapy Prescription

Patients Name: [redacted] Date 6/23/10

Diagnosis: 1. C TL Strain

Diagnosis: 2.

Diagnosis: 3

Diagnosis: 4

Evaluate & Treat: X Area: C TL Spine

Evaluate & Treat: _____ Area: _____

Evaluate & Treat: _____ Area: _____

Evaluate & Treat: _____ Area: _____

Frequency: 3 times/week Duration: 4 weeks Onset Date: _____

Precautions: _____

Physicians Name: Martin Quiroga, DO

Physicians Signature: _____ Date: 6/23/10

Choice HouseCall
17200 E. 10 Mile Rd. Suite 135
Eastpointe, MI 48021
Phone: (586) 279-3200 Fax: (586) 279-3184

Physical Therapy Prescription

Patients Name: _____ Date 12/22/10

Diagnosis: 1. C/L [illegible]

Diagnosis: 2. _____

Diagnosis: 3 _____

Diagnosis: 4 _____

Evaluate & Treat: ∝ Area: C/L

Evaluate & Treat: _____ Area: _____

Evaluate & Treat: _____ Area: _____

Evaluate & Treat: _____ Area: _____

Frequency: 3 times/week Duration: 4 weeks Onset Date: _____

Precautions: _____

Physicians Name: Andrew Ruden, M.D.

Physicians Signature: _____ Date: 12/22/10

[illegible] 9:50AM No. 0224 P. 7

4930

MUNDY PAIN CLINIC

6240 RASHELLE DR. SUITE 103 FLINT, MI 48507
PHONE: 810-232-9800, FAX: 810-232-7710

Occupational Therapy Prescription

Patients Name: ______ Date: 2/8/11

Diagnosis: 1. CWD [illegible] concussion h/a

Diagnosis: 2. (R) shld [illegible]

Diagnosis: 3

Diagnosis: 4

Evaluate & Treat: ∝ Area: back

Evaluate & Treat: 2 Area: (R) shoulder

Evaluate & Treat: ______ Area: ______

Evaluate & Treat: ______ Area: ______

Frequency: 3 times/week Duration: 4 weeks Onset Date: ______

Precautions: ______

Physicians Name: Andrew Ruden M.D.

Physicians Signature: ______ Date: 2/8/11

CHOICE HOUSE CALL
17200 E. 10 Mile Rd. Suite 135
Eastpointe, MI 48021
Phone: (586) 279-3200 Fax: (586) 279-3184

Occupational Therapy Prescription

Patients Name: _____ Date 2/8/10

Diagnosis: 1. T & L strain

Diagnosis: 2.

Diagnosis: 3

Diagnosis: 4

Evaluate & Treat: X Area: T & L Spine

Evaluate & Treat: _____ Area: _____

Evaluate & Treat: _____ Area: _____

Evaluate & Treat: _____ Area: _____

Frequency: 3/wk Duration: 4 wks Onset Date: 1/6/10

Precautions: _____

Physicians Name: R. Gunabalan MD

Physicians Signature: R Gunabalan Date: 2/8/10

CHOICE HOUSE CALL
17200 E. 10 Mile Rd. Suite 135
Eastpointe, MI 48021
Phone: (586) 279-3200 Fax: (586) 279-3184

Physical Therapy Prescription

Patients Name _____ Date 3/1/10

Diagnosis: 1. T + C spine

Diagnosis: 2. _____

Diagnosis: 3 _____

Diagnosis: 4 _____

Evaluate & Treat: ^ Area: T + L spine

Evaluate & Treat: _____ Area: _____

Evaluate & Treat: _____ Area: _____

Evaluate & Treat: _____ Area: _____

Frequency: 3/wk Duration: 4 wks Onset Date: 1-6-10

Precautions: _____

Physicians Name: R Gunabalan MD

Physicians Signature: R Gunabalan Date: 3-1-10

5:30

MUNDY PAIN CLINIC

6240 RASHELLE DR. SUITE 103 FLINT, MI 48507
PHONE: 810-232-9800, FAX: 810-232-7710

Occupational Therapy Prescription

Patients Name: [redacted]

Diagnosis: 1. Cervical Disc C_5-C_6-C_7 Pain

Diagnosis: 2. Lt Back Pain

Diagnosis: 3. _____

Diagnosis: 4. _____

Evaluate & Treat ____ Area: _____

Evaluate & Treat ____ Area: _____

Evaluate & Treat ____ Area: _____

Evaluate & Treat ____ Area: _____

Frequency: 3 Duration: 4 Weeks On Date: 3/27/11

Precautions: _____

Physicians Name: Dr. Hoban

Physicians Signature: [signature] Date: 5/3/11

Mundy Pain Clinic P.C.
6240 Rashelle Drive, Suite 103
Flint, MI 48507
Phone: 810-232-9800
Fax: 810-232-7710

PHYSICAL THERAPY SCRIPT

Patient's Name: _____ Date: 5/3/11

Diagnosis : 1. Whip lash near Mid

Diagnosis: 2. LW Back Pain C5-7 Disc bgn

Diagnosis: 3. _____

Diagnosis: 4. _____

Evaluate and Treat _____ Area Neck

Evaluate and Treat _____ Area LW Back

Evaluate and Treat _____ Area _____

Evaluate and Treat _____ Area _____

Frequency: 3 week Duration: 4 weeks Onset Date: 3/27/11

Precautions: _____

Physician's Name: Dr. Hoban

Physician's Signature: [signature] Date: 5/3/11

04/09/2008 15:31 FAX 12483541114 FAXMEDICALEVALUATIONS 001/001

Medical Evaluations, P.C
21411 Civic Center Dr Ste 102
Southfield, Mi 48076
Phone: 248-354-1111 Fax: 248-354-1114

PRESCRIPTION FOR PHYSICAL & OCCUPATIONAL THERAPY

Patients Name: [redacted] Date: 11/17/11

Diagnosis 1: Cervical [illegible]

Diagnosis 2: [illegible]

Diagnosis 3: [illegible]

Diagnosis 4:

Evaluate and Treat: / Area:

Evaluate and Treat: / Area: 2

Evaluate and Treat: / Area: 3

Evaluate and Treat: Area:

Other:

Frequency: 3x wk Duration: 4wks Onset Date:

Precautions:

Physician's Name: Beale

Physician's Signature: [signature]